105TH CONGRESS
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HOUSE OF REPRESENTATIVES
REPORT
105–165

WAIVER OF 75/25 MEDICAID ENROLLMENT RULE FOR BETTER HEALTH PLAN, INC.

JULY 8, 1997.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. BLILEY, from the Committee on Commerce, submitted the following

REPORT

[To accompany H.R. 2018]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred the bill (H.R. 2018) to waive temporarily the Medicaid enrollment composition rule for the Better Health Plan of Amherst, New York, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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AMENDMENT

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. WAIVER OF 75/25 MEDICAID ENROLLMENT RULE FOR BETTER HEALTH PLAN, INC.

Effective July 1, 1997, the requirement of section 1903(m)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(ii)) is waived, for contract periods through December 31, 1998, with respect to the Better Health Plan, Inc., operating in New York.

PURPOSE AND SUMMARY

Section 1903 (m)(2)(a)(ii) of the Social Security Act requires that Medicaid beneficiaries constitute less than 75 percent of the membership of any prepaid health maintenance organization. H.R. 2018 extends an existing waiver of Section 1903(m)(2)(A)(ii) granted to Better Health Plan, Inc. operating in the State of New York through December 31, 1998. The current waiver expired on June 30, 1997.

BACKGROUND AND NEED FOR LEGISLATION

State experimentation with health maintenance organizations (HMOs) began shortly after the implementation of Medicaid. The origin of the 75/25 rule arose out of concerns relating to certain managed care companies. These concerns included inaccurate information dissemination to enrollees, restricted access to non-participating providers, inconsistent provision of benefits, and, in certain cases, financial instability of the enrolling plan.

Reports of these irregularities led to Congressional action that has spanned the last twenty years. The first Federal action addressing Medicaid HMO contracts came with the Health Maintenance Organization Amendments of 1976 (P.L. 94–46). This measure, the predecessor of the current 75/25 rule, limited the percentage of Medicaid and Medicare beneficiaries enrolled in risk contracts to 50 percent. An exception applied to Federally-funded centers and pre-1970 contractors. New contractors had up to three years to meet the requirement if they could show that they were making satisfactory progress towards compliance. The 1976 measure also limited new State prepaid initiatives to established organizations which could meet the Federal qualifications.

The 1976 measure had the unintended effect of sharply limiting managed care enrollment by Medicaid beneficiaries. As of 1981, scarcely more than 1 percent of the Medicaid population (281,926 beneficiaries) were enrolled in HMOs. Of that number, fully 85 percent were located in just four States: California, Maryland, Michigan, and New York.

In light of this experience, Congress again addressed managed care enrollment by Medicaid beneficiaries in the Omnibus Budget Reconciliation Act of 1981. Among the changes made by OBRA 81 (P.L. 97–35) to Federal Medicaid HMO contracting rules were the following changes. The allowable percentage of Medicaid beneficiaries that could be enrolled in HMOs was increased to 75 percent from 50 percent. This permitted plans to tailor their services to Medicaid beneficiaries and the communities in which they reside. In addition, Medicaid contracts were no longer limited to Federally qualified HMOs, allowing States to determine the qualified status of plans if they demonstrated an ability to provide covered

services and if they could protect beneficiaries from financial liability should the organization become insolvent.

Despite these advances, current Medicaid law creates significant obstacles for plans that focus on the needs of low-income communities. Although these plans have achieved notable success in enhancing the quality of care received by area Medicaid beneficiaries, they have been less successful in attracting commercial clients from outlying areas. The requirement that one-quarter of their enrolled population consist of such customers, therefore, often places them in the difficult position of having to choose between devoting resources to their Medicaid-funded enrollees or to the expense of competing against broader-based firms for commercial clients.

In light of the burdens created by this situation, this measure extends the existing waiver of the 75/25 requirement of Section 1903(m)(2)(A)(ii) for Better Health Plan, Inc. operating in the State of New York.

Better Health Plan, Inc. is a Medicaid Prepaid Health Services Plan approved by the New York State Department of Health which operates in the five boroughs of New York City as well as eleven counties. It serves over 41,500 individuals, of which 36,700 are Medicaid recipients. Better Health Plan has been a leader in providing prenatal and infant care. The "Better Health for Babies" program was designed to improve the health of the mother and reduce infant morbidity and mortality. This program is one of the most successful in the State of New York.

HEARINGS

The Committee on Commerce has not held hearings on the legislation.

COMMITTEE CONSIDERATION

H.R. 2018, a bill to waive temporarily the Medicaid enrollment composition rule for the Better Health Plan of Amherst, New York, was introduced on June 24, 1997, by Congressmen Paxon, Towns, Engel, Lazio of New York, and Manton.

On Wednesday, June 25, 1997, the Full Committee met in open markup session and ordered H.R. 2018 reported to the House, amended, by a voice vote, a quorum being present.

ROLLCALL VOTES

Clause 2(l)(2)(B) of rule XI of the Rules of the House requires the Committee to list the recorded votes on the motion to report legislation and on amendments thereto. There were no recorded votes taken in connection with ordering H.R. 2018 reported or in adopting the amendment. An amendment offered by Mr. Paxon to insert an effective date of July 1, 1997, was adopted by a voice vote. A motion by Mr. Bliley to order H.R. 2018 reported to the House, amended, was agreed to by a voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this legislation.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, the Committee finds that H.R. 2018 would result in no new or increased budget authority or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 3, 1997.

Hon. TOM BLILEY,
Chairman, Committee on Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2018, a bill to waive temporarily the Medicaid enrollment composition rule for the Better Health Plan of Amherst, New York.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Jeanne De Sa (for federal costs), and John Patterson (for the state and local impact).

Sincerely,

PAUL VAN DE WATER
(For June E. O'Neill, Director).

Enclosure.

H.R. 2018.—To waive temporarily the Medicaid enrollment composition rule for the Better Health Plan of Amherst, New York

H.R. 2018 would extend a waiver of the enrollment composition requirement in Title XIX of the Social Security Act for the Better Health Plan of Amherst, New York. Under current law, public health maintenance organizations must have at least 25 percent of their enrollment from the private sector and no more than 75 percent from Medicare and Medicaid. The Better Health Plan's waiver expired on June 30, 1997. H.R. 2018 would extend the waiver through December 31, 1998.

The Better Health Plan has 41,500 enrollees, of whom 37,000 are Medicaid recipients. In the absence of the waiver, the plan's Medic-

aid enrollment would be limited to 31,000 people. CBO estimates that extending the waiver would reduce federal Medicaid spending in 1998 and 1999, but the effect would not be significant.

H.R. 2018 does not contain any intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995 and would impose no costs on state, local, or tribal governments. Because the State of New York pays 50 percent of Medicaid costs, its Medicaid spending would also be reduced by extending the waiver.

The CBO staff contacts for this estimate are Jeanne De Sa (federal costs), who can be reached at 226–9010, and John Patterson (state and local costs), who can be reached at 225–3220. This estimate was approved by Paul N. Van de Water, Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Waiver of 75/25 Medicaid Enrollment Rule for Better Health Plan, Inc.

This section provides that effective July 1, 1997, the requirement of Section 1903(m)(2)(A)(ii) of the Social Security Act is waived with respect to the Better Health Plan, Inc. operating in New York, for contract periods through December 31, 1998.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

This legislation does not amend any existing Federal statute.

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